Original articles

Does liberal abortion improve perinatal outcome?

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1 Introduction

In March 1970, Hawaii became the first State in the U.S.A. to introduce a liberal abortion law, permitting abortion essentially "on request" [22]. Little is known about the possible effects that such termination of unwanted pregnancies might have upon perinatal mortality and morbidity.

EVRARD suggested that liberal abortion might result in the termination of a significant number of "high risk" pregnancies [5]. It is accepted that the number of illegitimate births in the United States (and in Hawaii) had been increasing in the sixties [21]. In a University population there was an associated increase in rates of prenatal deaths (stillbirths) as well as prematurity (low birth weight) [2]. This suggests that illegitimacy alone, rather than prenatal care or social class, contributes to poor pregnancy outcome.

A high percentage (63%) of women undergoing elective abortion in the State of Hawaii were unmarried [22]. Of these illegitimate conceptions, 40% were in women less than 18 years of age (a group with a high perinatal mortality [1, 25]). Because of this the following questions were asked:

a) Does liberal abortion affect perinatal mortality?
b) Does liberal abortion decrease the "high risk" categories of illegitimate and teenage pregnancies?
c) Does liberal abortion decrease low birth weight incidence and hence neonatal mortality and morbidity?

Curriculum vitae

ALISTAIR PHILIP *studied medicine at the University of Edinburgh, Scotland from 1955 to 1961. He received neonatal training in Boston (U.S.A.) from 1965–67, Edinburgh, from 1967–69, and Paris, 1969. He was the neonatologist from 1970 to 1974 at Kapiolani Hospital and Kauikeolani Children's Hospital, Honolulu, Hawaii, while holding the position of Assistant Professor of Pediatrics at the University of Hawaii. Currently he is Associate Professor of Pediatrics at the University of Vermont and Co-Director of the Vermont/New Hampshire Regional Perinatal Program. His research interests include placental transfusion, intrauterine growth retardation and neonatal infection.*

2 Material and methods

All babies delivered at Kapiolani Hospital (formerly Kapiolani Maternity and Gynecological Hospital) **from January 1966 to December 1974 were included** in this survey. The years 1966 to 1969 were "pre-abortion" and 1971 to 1974 "post-abortion", with 1970 indeterminant. There were between 4,000 and 5,000 deliveries per year, representing more than one-half of all civilian deliveries in the City and County of Honolulu, and approximately one-third of all deliveries in the State of Hawaii. The daily admission records of both the delivery room and the newborn nursery for the period under review were checked by the author for the number

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of livebirths and stillbirths (weighing more than 500 grams) and low birth weight infants (less than 2.500 grams). Neonatal deaths were collected from the record room and by follow-up of any infant transferred to another hospital (e.g., infants requiring prolonged respirator support or neonatal surgery are transferred to Kauikeolani Children's Hospital). Infants admitted to Kapiolani Hospital from another hospital were not included in the analysis. Although there are undoubtedly more "high risk pregnancies" delivered at Kapiolani Hospital (reflected in the increased incidence of low birth weight infants) the patterns of referral did not change during the period of study.

Products of the intentional termination of pregnancy were not included in the analysis of perinatal deaths. Pregnancies lasting beyond 20 weeks gestation occasionally produced "abortuses" weighing more than 500 grams. These accounted for less than 1% of all intentionally aborted pregnancies.

It was not possible to assess the effects upon perinatal morbidity in the two time periods because of 1) inadequate gestational age assessments, 2) uncertainty of diagnosis of respiratory distress syndrome, etc., 3) a more aggressive diagnostic and therapeutic approach after 1970, and 4) earlier discharge of low birth weight infants in the last few years.

3 Results

There was no change in the percentage of total births in the state (30%) which occurred at Kapiolani Hospital in the pre- and post-abortion periods. Illegitimate live births were also constant at 45% of the state figures for the respective time periods (Tab. I). **The proportion of low birth weight babies (500–2500 grams) born at Kapiolani Hospital fell from 8.9% to 8.0% of all live births.** This was reflected in the State of Hawaii numbers, where there was a fall from 8.0% to 7.1%.

An increase in both illegitimate births and stillbirths was observed both in the State of Hawaii and at Kapiolani Hospital. Illegitimate births were associated with markedly increased rates for both low birth weight and perinatal moatality (Tabs. I and II). **There was a slight increase in perinatal deaths in illegitimate pregnancies.** Tab. II shows that other (total, over 1000 gram and non-illegitimate) perinatal mortality rates decreased, although there were no significant differences for pre-and post-abortion time periods.

Almost half of all illegitimate births in the State occurred at Kapiolani Hospital. Data from the hospital were not available, but it was interesting to compare the maternal age of such pregnancies for the state of Hawaii. **Illegitimate births were disproportionately distributed with teenagers**

Tab. I. Perinatal statistics for 4-year periods pre- and post-abortion law at Kapiolani hospital and for the state of Hawaii.

	Kapiolani Hospital				*State of Hawaii*			
	1966–69		*1971–74*		*1966–69*		*1971–74*	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Live Births	17,554		19,573		59,993		62,088	
Illegitimate Births	2,466	14.0%	2,774	14.2%	5,444	9.1%	6,114	9.8% †
Stillbirths	125	7.1/1000	157	8.0/1000	798	13.1/1000	1,230	19.4/1000 *†
Neonatal Deaths	214	12.2/1000	184	9.4/1000°	883	14.7/1000	753	12.1/1000 †
Low Birth Weight	1,567	8.9%	1,562	8.0% **	4,772	8.0%	4,389	7.1% †
Low Birth Weight Neonatal Deaths	166	106.0/1000	154	99.0/1000	Not available		Not available	
Illegitimate Low Birth Weight	295	12.0%	287	10.3%	Not available		Not available	

* Probably represents over-reporting (of legal abortions) in 1971 and 1972.
% $P < 0.05$
** $P < 0.005$
† $P < 0.001$

Tab. II. Perinatal deaths (with rates per 1,000 in parentheses), Kapiolani Hospital, State of Hawaii, Pre- and Post Abortion Law.

	1966–69		1971–74		%Change	P
Live Births and Stillbirths	17,679		19,730		+11.6	
All Perinatal Deaths	333	(18.8)	335	(17.0)	– 9.6	n.s.
Perinatal Deaths > 1,000 Grams	234	(13.3)	224	(11.4)	–14.3	n.s.
Illegitimate Perinatal Deaths	60	(24.3)	70	(25.2)	+ 3.7	n.s.
Non-Illegitimate Perinatal Deaths	273	(18.0)	265	(15.6)	–13.3	n.s.

accounting for 40.1% in the "pre-abortion" years, and 47.2% in the "post-abortion" years. Fig. 1 shows that despite very large numbers of abortions being performed for illegitimate pregnancies, and teenage pregnancies, the number of live births in each of these categories showed only a transient

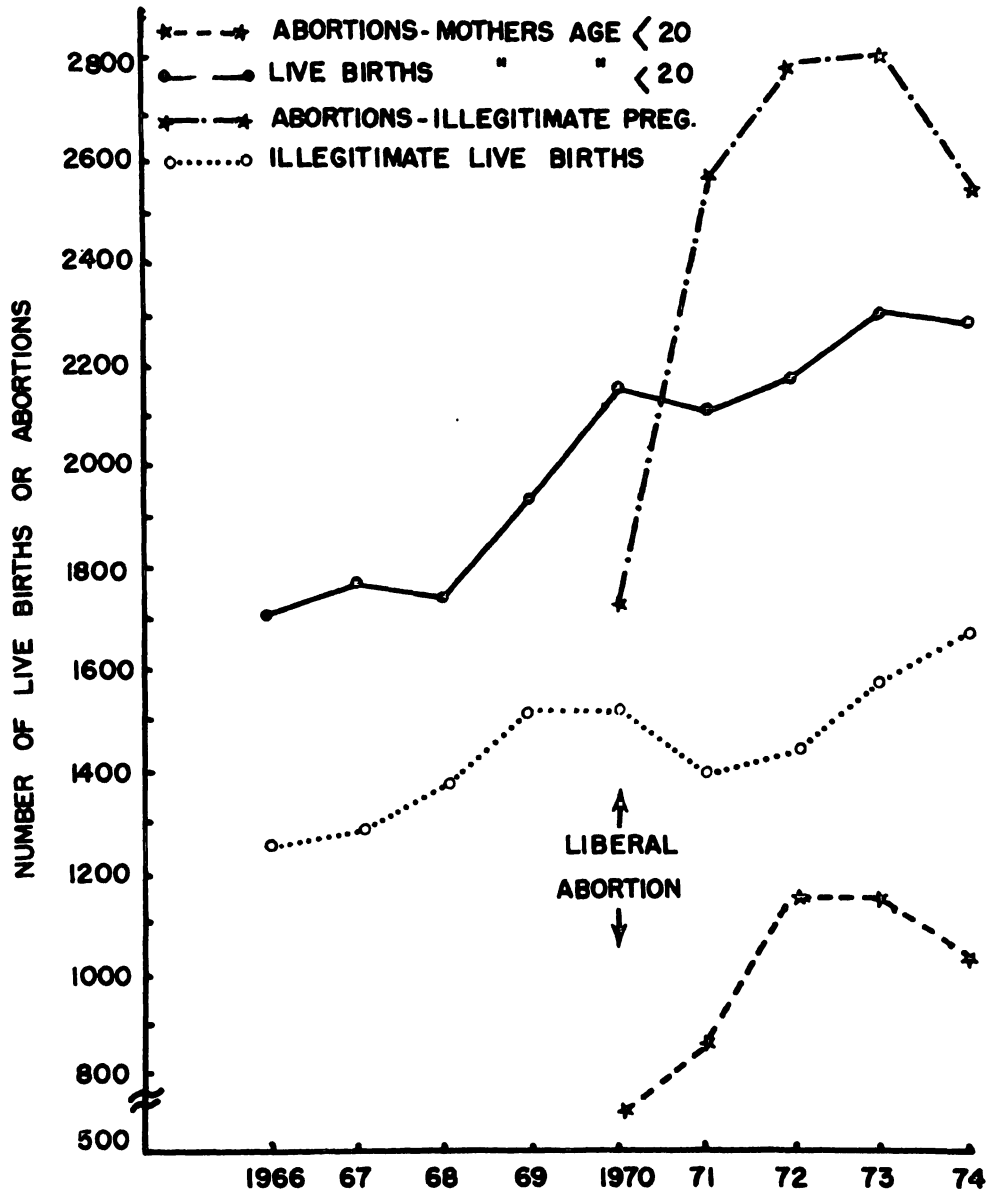

Fig. 1. Live births and legal abortions of illegitimate and teenage pregnancies, State of Hawaii 1966–74.

decline. Fig. 2 shows that teenage illegitimate pregnancies accounted for an increasing percentage of all illegitimate pregnancies in the late 1960's, and after a transient fall are continuing to rise in total number, although the percentage of the total has remained fairly constant.

The increase in stillbirths is not easily explained for Kapiolani Hospital, but the State statistics almost certainly include "abortuses" in 1971 and 1972. The number of stillbirths at Kapiolani Hospital showed a marked decrease (65) in 1973–74 when compared to the number (95) in 1971–72.

A decrease in neonatal deaths and low birth weight infants was observed both at the hospital and in the State. The decrease in neonatal deaths was undoubtedly the result of many factors. For whatever reasons this decrease occurred, the fall in neonatal mortality was the major contributor to the observed decreases in perinatal mortality. The perinatal mortality rate for specific age groups (Tab. III) shows that the age range of 20–29 years had the lowest rate, in both pre- and post-abortion time periods. There was a statistically significant fall in this group in the post-abortion period, in contrast to the rise noted in the teenage population. **The teenage perinatal mortality rate was almost double that for mothers aged 20 to 29.**

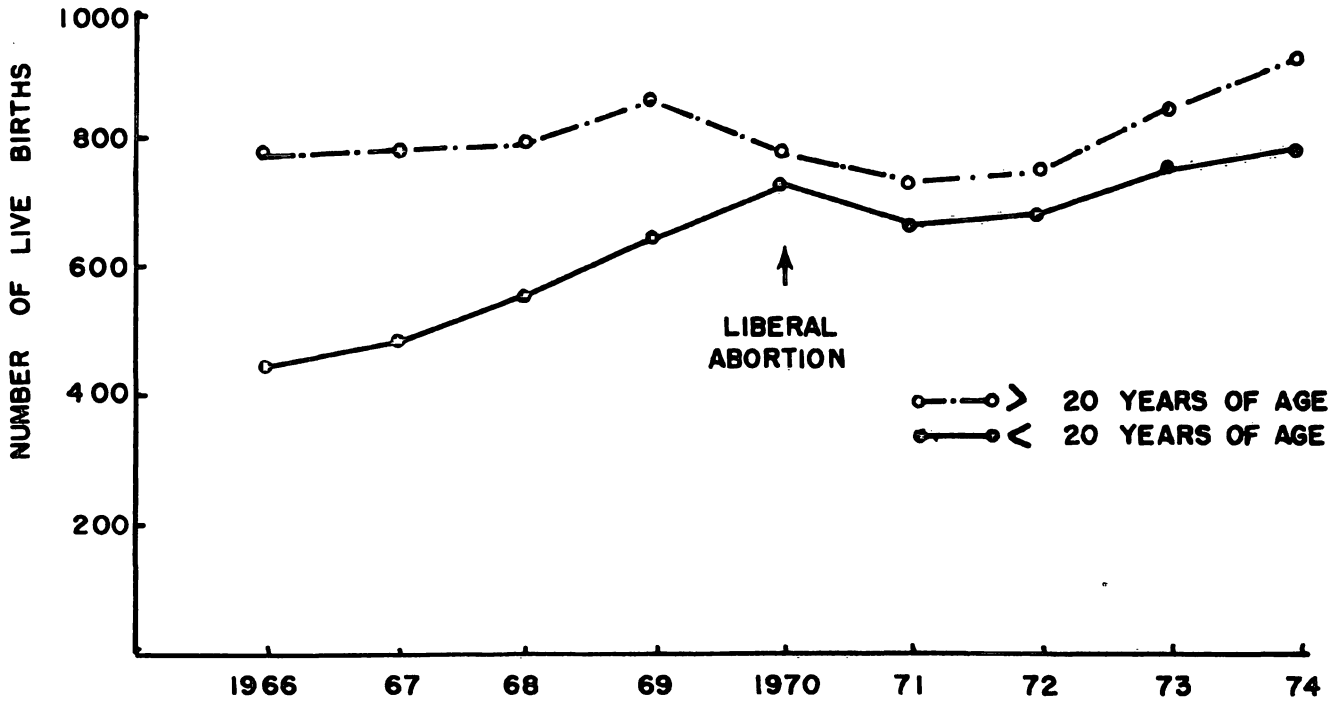

Fig. 2. Maternal age of illegitimate live births, State of Hawaii, 1966–74.

Tab. III. Perinatal mortality rates by maternal age (Kapiolani Hospital, State of Hawaii, Pre- and Post-Abortion)

Age (Years)	Livebirths		Perinatal Deaths		Perinatal Mortality Rate		P
	Pre-	Post-	Pre-	Post-	Pre-	Post-	
<20	2,106	2,799	45	71	21.4	25.4	n.s.
20–29	11,410	12,977	199	181	17.4	13.9	<0.05
30+	3,967	3,797	87	71	21.5	18.7	n.s.

Pre = 1966–69
Post = 1971–74

Tab. IV. Distribution of low birth weight infants by birth weight (Kapiolani Hospital)

Weight (grams)	1966–69	1971–74	Change in % of Total Births	P
2000–2499	1087	1064	–12%	<0.005
1500–1999	290	287	–11%	n.s.
1000–1499	116	126	– 3%	n.s.
500– 999	74	85	+ 2%	n.s.
Total Low Birth Weight	1,567	1,562	–10%	<0.005
Total Live Births	17,554	19,573		

There was a significant reduction (10.1%) in the percentage of low birth weight infants born in the post-abortion period. This change was entirely the result of a reduction in the percentage of infants weighing 1500–2500 grams (Tab. IV), rather than a decreased number of *very* low birth weight infants.

4 Discussion

Inresponse to the questions posed in the introduction, **a) liberal abortion, as it was utilized in Hawaii, did not produce a significant decrease in perinatal mortality; b) the number of illegitimate and teenage pregnancies were only transiently decreased, and the mortality rate of these two groups increased; c) there was a significant reduction in the total number of low birth weight infants born, which was reflected in a decreased neonatal mortality rate.**

In addition, perinatal mortality significantly decreased in babies born to mothers aged 20 to 29 years. This age group accounts for 60% of abortions (and live births).

4.1 Perinatal and neonatal mortality

Perinatal mortality consists of late fetal deaths and early neonatal deaths. A decrease in neonatal deaths is likely to result in a decrease in perinatal deaths, but only if stillbirths remain relatively constant. A decrease in low birth weight births almost invariably results in decreased neonatal mortality. Sweden has had a declining low birth weight rate and low perinatal mortality figures for many years, but the part played by legal abortion in this trend is uncertain [16, 17]. Studies from New York [6, 12] have claimed a reduction in neonatal mortality rates following introduction of liberalized abortion. This decrease was attributed to the smaller numbers of very low birth weight (500 to 1000 grams) babies being born. However, the population of Hawaii may be more representative of the U.S.A. than New York City, and in this survey there were very few babies with birth weights below 1000 grams before or after 1970.

Following the introduction of a more liberal abortion law in Canada, early evidence indicated a larger than usual decline in both neonatal and perinatal mortality rates, which was "presumably attributable to legal abortion [19]." In Japan, where liberal abortion has been available for many years, both neonatal and perinatal mortality rates have been rapidly falling [17]. Experience from Romania is perhaps the most convincing. After repeal of a liberal abortion law in 1966 there was a sharp rise in neonatal mortality rate from 14.8 in 1966 to 23.7 and 25.4 in 1967 and 1968. A gradual fall over the next three years was attributed to a greater use of illegal abortion [27].

In contrast to these studies, the experience from Hungary suggests that liberal abortion resulted in an increase in the number of low birth weight infants and halted a decline in perinatal mortality. Perinatal mortality remained at 33 to 37 per 1000 live births from two years after liberal abortion (1958) until the end of the sixties, having been 51.6 per 1000 live births in 1948 [10].

4.2 Illegitimacy and teenage pregnancy

A liberal abortion policy introduced in Canada in 1969 resulted in the first decrease in the number of

illegitimate births since 1949. This was particularly striking in those places (British Columbia, Ontario, and Alberta) where most abortions occurred. There also appeared to be a growing number of abortions in single teenagers [19].

In the U.S.A. the illegitimate birth rate increased steadily from 1965 to 1970, and in 1971 showed a big drop in states with liberal abortion laws and a small drop in "non-abortion" states. The teenage illegitimate birth rate rose from 17.6 in 1965 to 23.3 in 1970, but dropped back to 22.5 in 1971 [21]. In California there was a slight decrease in all illegitimate births in 1971 after liberal abortion was introduced in 1970, but white illegitimate births increased in the following year (1972) [20]. In Great Britain there has been a continued slow rise in the number of teenage illegitimate births [7b]. A similar experience was noted in Hawaii. There was a transient slight decrease in both illegitimate and teenage pregnancies in 1971, but a sustained rise in subsequent years. In contrast to the British experience where only about 5% of illegitimate births were in teenagers [7b], in Hawaii almost 50% were teenagers. Because of the high incidence of low birth weight babies born to both teenage and unwed mothers (Tabs. II and III), it is unfortunate that such a trend has been established.

4.3 Low birth weight

The immediate decrease in the number of low birth weight infants born in New York City following liberal abortion has been mentioned. Liberal abortion laws in Japan and Sweden are associated with decreased rates of low birth weight infants (4–5%) [17].

A long-term effect of increased numbers of low birth weight babies was noted following legal abortion in Hungary [11], and illegal abortion in Greece [14, 15]. Recent studies from Yugoslavia [9], Japan [18] and Taiwan [3] found no association between induced abortion and subsequent pregnancy outcome. It is possible that the method used to induce abortion may influence outcome. Dilatation and curettage were used extensively in Greece [14, 15], whereas vacuum aspiration was favored in Yogoslavia [9]. A combined method was most frequently used in Hawaii [22].

In England and Wales the low birth weight rate decreased somewhat, 4 years after introduction of a more liberal abortion law [7a]. Two more years later the rate was even lower [17].

The experience in Hawaii needs to be extended, but the preliminary findings suggests that the low birth weight rate is continuing to fall. For instance, at Kapiolani Hospital, in 1975 the low birth weight rate was 7.2% (compared to 8.0% for 1971–1974).

4.4 Modifying factors

There are at least three reasons why a more striking effect upon perinatal mortality was not seen. **First, the perinatal mortality rate for the hospital was already quite low. Second, there were very few babies in the very low birth weight group** (less than 1000 grams) born at Kapiolani Hospital before *or* after introduction of liberal abortion. This is in contrast to experience in New York City. Thirdly, it is very possible that many high risk pregnancies were being terminated before introduction of a liberal law. In New York it has been estimated that approximately 70% of legal abortions replaced illegal abortion, [24]. A similar estimate has been made for the whole U.S.A. [21], and in Hawaii "half the women (51.3%) said that if abortion were illegal. . . . they would have tried to get an abortion somehow [4]."

In addition, it may have been more difficult for teenagers to obtain an abortion in Hawaii, since women under 18 years of age had to have parental permission [23]. Teenagers also seem to be more conservative in their attitudes towards abortion than adults [28].

5 Conclusion

Only minor changes in perinatal statistics were observed after introduction of a law allowing abortion essentially "on request." The observed decrease could be ascribed to improved obstetrical and neonatal practices such as electronic fetal heart rate monitoring and assisted ventilation. Liberal abortion may have contributed to a reduction in perinatal mortality in the group with the lowest mortality rate (20–29 years of age). Perinatal

mortality did not decrease in the "high risk" teenage population.

Measures which delay childbearing into the twenties are likely to improve perinatal outcome [13]. **Use of other birth control measures did not decrease after liberal abortion was introduced in Hawaii.** Although the rate of non-use was still high, there was an increase in the percent using birth control in women seeking abortion [22]. **Any future reduction in the numbers of teenage and illegitimate pregnancies might come through birth control measures without invoking the help of abortion** [8, 26].

6 Summary

In March 1970, Hawaii became the first State in the U.S.A. to allow abortion essentially at the request of the mother. The possibility that many "high risk" pregnancies might consequently be eliminated lead to examination of perinatal statistics in a hospital accounting for one-third of all deliveries in the State. Four years (1966–69) preceding and four years (1971–74) following the introduction of liberalized abortion were examined.

The following questions were asked:

a) Does liberal abortion affect perinatal mortality?
b) Does liberal abortion decrease the "high risk" categories of illegitimate and teenage pregnancies?
c) Does liberal abortion decrease low birth weight incidence and hence neonatal mortality and morbidity?

The answers obtained were as follows:

a) **Liberal abortion, as it was utilized in Hawaii, did not produce a significant decrease in perinatal mortality;**
b) **Both illegitimate and teenage pregnancies continued to increase in this population, with concomitantly increased mortality rates;**
c) **There was a significant decrease in the incidence of low birth weight infants, which was reflected in a decreased neonatal mortality rate.**

The stillbirth rate rose while the neonatal death rate and the low birth weight rate dropped (Tab. I). Although there was a drop in perinatal mortality rate (18.8 to 17.0 per 1000), "standard" perinatal mortality rate (includes only births with weight over 1000 grams) (13.3 to 11.4 per 1000), and non-illegitimate perinatal mortality rate (18.0 to 15.6 per 1000), the rate of illegitimate perinatal deaths increased (24.3 to 25.2 per 1000) (Tab. II).

Perinatal mortality rate increased from 21.4 to 25.4 per 1000 in the teenage population (Tab. III), but decreased from 17.4 to 13.9 per 1000 in mothers aged 20 to 29 years (a group which accounts for 60% of both abortions and livebirths).

The drop in low birth weight infants was 10% and was primarily in infants weighing 1500 to 2500 grams (Tab. IV).

These results do not show a direct cause and effect relationship, but do support the evidence from other countries which suggests that liberalized abortion contributes positively to decreasing neonatal and perinatal mortality. Further experience is required, but the low birth weight rate was 7.2% in 1975. This suggests that an increase in low birth weight rates is unlikely. Whether or not the method of inducing abortion affects the incidence of subsequent low birth weight births is unclear at this time.

Factors which may account for a less dramatic fall in perinatal mortality rate than that seen elsewhere are a) an already low perinatal mortality rate; b) few very low birth weight infants before or after the liberal abortion law; and c) probability that there were many illegal abortions taking place prior to the new law.

Keywords: Abortion, illegitimate, low birth weight, perinatal mortality, pregnancy, teenage.

Zusammenfassung

Verbessert die Freigabe des Schwangerschaftsabbruches die perinatalen Mortalitäts- und Morbiditätsziffern?

Im März 1970 wurde Hawaii der erste Staat in den Vereinigten Staaten, in dem eine Schwangerschaftsunterbrechung im wesentlichen auf Antrag der Mutter zulässig war. Die Möglichkeit, daß dadurch viele Risikoschwangerschaften eliminiert werden könnten, führte zu einer Überprüfung der perinatalen statistischen Daten in einem Krankenhaus, in dem ein Drittel aller Geburten dieses Staates erfolgen. 4 Jahrgänge (1966–69) vor und 4 Jahre (1971–74) nach Einführung der Liberalisierung des Schwangerschaftsabbruches wurden untersucht.

Folgende Fragen wurden gestellt: a) Beeinflußt die Liberalisierung des Schwangerschaftsabbruches die perinatale Mortalität? b) Verkleinert sie die Risikogruppen der unehelichen und Teenage-Schwangerschaften? c) Vermindert die Häufigkeit der Untergewichtigkeit und damit die neonatale Mortalität und Morbidität?

Folgende Antworten wurden erhalten:

a) **Die Liberalisierung des Schwangerschaftsabbruches, so wie sie in Hawaii angewandt wurde, hatte keinen signifikanten Einfluß auf die perinatale Mortalität.** b) **Sowohl die unehelichen wie die Teenager-Schwangerschaften nahmen weiterhin zu in dieser Population, was eine erhöhte Mortalitätsrate im Gefolge hatte.** c) **Es fand sich ein signifikanter Rückgang in der Häufigkeit von untergewichtigen Neugeborenen, die sich in einer geringeren neonatalen Mortalitätsrate wiederspiegelte.**

Die Totgeburtenrate stieg an, während die neonatale Mortalität und die Rate an untergewichtigen Kindern absank (Tab. I). Obwohl ein Rückgang in der perinatalen Mortalitätsrate (18,8 auf 17,0 pro 1000), in der standardisierten perinatalen Mortalitätsrate (diese umfaßt

nur Geburtsgewichte über 1000 g) (13,3 auf 11,4 pro 1000) und bei der Mortalitätsrate ehelich geborener Kinder (18,0 auf 15,6 pro 1000) zu verzeichnen war, hat die Rate perinataler Todesfälle illegitim geborener Kinder zugenommen (24,3 auf 25,2 pro 1000) (Tab. II). Die perinatale Mortalitätsrate stieg von 21,4 auf 25,4 pro 1000 in der Population der Teenager-Schwangeren an (Tab. III), nahm jedoch bei den Müttern zwischen 20 und 29 Jahren (die Gruppe, in der 60% aller Aborte und Geburten mit einem lebenden Kind vorkamen) von 17,4 auf 13,9 pro 1000 ab.
Der Rückgang der Kinder mit niedrigen Geburtsgewicht betrug 10% und wurde vorwiegend bei Kindern in der Gewichtsklasse von 1500 bis 2500 g (Tab. IV) verzeichnet.

Diese Resultate zeigen keine direkte ursächliche Beziehung mit der perinatalen Mortalität. Sie unterstützen jedoch die Hinweise, die aus anderen Ländern stammen und die vermuten lassen, daß sich die Freigabe des Schwangerschaftsunterbruches positiv auf das Absinken der neonatalen und perinatalen Mortalität auswirkt. Wir benötigen weitere Erfahrungen; die Rate an Kindern mit einem niedrigen Geburtsgewicht betrug 1975 7,2%. Dies läßt vermuten, daß eine Zunahme an Kindern mit niedrigem Geburtsgewicht unwahrscheinlich ist. Ob die Art der Abortinduktion die Häufigkeit von Geburten mit niedrigem Geburtsgewicht in der Folge beeinflußt, ist zu diesem Zeitpunkt ungeklärt.
Folgende Faktoren könnten für den wenig eindrucksvollen Rückgang der perinatalen Mortalitätsrate im Vergleich zu anderen Ländern verantwortlich sein: a) Eine bereits niedrige perinatale Mortalitätsrate, b) eine geringe Anzahl an Kindern mit sehr niedrigem Geburtsgewicht vor oder nach der gesetzlichen Freigabe des Schwangerschaftsabbruches und c) die Möglichkeit, daß es vor Einführung des neuen Gesetzes viele illegale Aborte gab.

Schlüsselwörter: Perinatale Mortalität, Schwangerschaft, Schwangerschaftsabbruch, Teenager-Schwangerschaften, tiefes Geburtsgewicht, unehelich Geborene.

Résumé

La liberalisation de l'avortement permet-elle d'améliorer la situation de la périnatalitéÑ
En mars 1970, Hawaii fut le premier Etat des USA à autoriser l'avortement essentiellement à la demande de la mère. Désireux de savoir si cette mesure libérale permettrait de réduire le nombre des grossesses à «haut risque», on procéda à l'étude des statistiques périnatales sur les 4 années ayant précédé cette mesure (1966–69) et les 4 années lui ayant succédé (1971–74), et cela dans un hôpital totalisant le tiers des accouchements dans l'Etat de Hawaii.

Les recherches se limitèrent aux questions suivantes:

a) L'avortement libéral a-t-il une influence sur la mortalité périnatale?
b) L'avortement libéral a-t-il entraîné une diminution des catégories à «haut risque» des grossesses illégitimes et des teens?
c) L'avortement libéral a-t-il provoqué une baisse de l'incidence des souspoids de naissance et, par là, de la mortalité et de la morbidité néonatales.

Les réponses obtenues ont été les suivantes:

a) **L'avortement libéral tel qu'il a été pratiqué à Hawaii n'a produit aucune baisse significative de la mortalité périnatale'**
b) **Les grossesses illégitimes ainsi que des teens ont continuç á augmenter dans la population de cet Etat, avec une hausse simultané du taux de mortalité.**
c) **On observa, par contre, une diminution significative de l'incidence des bébés à souspoids de naissance qui entraîna une baisse du toaux de mortalité néonatale.**

Le taux des bébés morts-nés augmenta tandis que celui de la mortalité néonatale et celui des souspoids de naissance baissa (Tab. I). Bien qu'il s'ensuivit une baisse de la mortalité périnatale (18,8 à 17,0 per 1000), de la mortalité périnatale (18,8 à 17,0 per 1000), de la mortalité périnatale «standard» (c.à.d. l'exclusion des poids de naissance inférieurs à 1000 grammes) (13,3 à 11,4 per 1000) et de la mortalité périnatale illégitime (18,0 à 15,6 per 1000), on releva une croissance du taux de la mortalité périnatale illégitime (24,3 à 25,2 per 1000) (Tab. II).
Le taux de mortalité périnatale a augmenté de 21,4 à 25,4 per 1000 dans la population des teens (Tab. III), mais a baissé de 17,4 à 13,9 per 1000 chez les mères âgées de 20 à 29 ans (un groupe qui totalise 60% des avortements ainsi que des naissances vivantes).
La baisse du pourcentage des souspoids de naissance a atteint 10% et a concerné primairement les bébés pesant entre 1500 et 2500 grammes (Tab. IV).
Ces résultats ne prouvent pas une relation directe de cause à effet, mais semblent, toutefois, confirmer les observations faites dans d'autres pays et selon lesquelles la libération del'avortement paraîtrait contribuer positivement à réduire le taux de mortalité néonatale et périnatale. Les recherches doivent continuer, mais le taux des souspoids étant tombé à 7,2% en 1975, il semble improbable qu'il remonte dans l'avenir. Il reste encore à préciser si la méthode d'induction des avortements influence l'incidence des naissances subséquentes avec souspoids.
On arelevé également trois facteurs éventuels qui rendraient la baisse de la mortalité périnatale moins inattendue qu'ailleurs: a) un taux déjà bas de la mortalité périnatale; b) le nombre restreint d'enfants au souspoids très grave avant ou après la loi de libéralisation des avortements; c)l'existence probable d'un très grand nombre d'avortements illégaux avant la promulgation de la nouvelle loi.

Mots-clés: Avortement, grossesse, illégitime, mortalité périnatale, souspoids de naissance, teens

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